

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034343

FILED VS SEP 19 1960

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 216

1. PLACE OF DEATH a. COUNTY Franklin				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		Length of stay in 1b D.O.A.		c. CITY OR TOWN Sullivan, Missouri		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital		DOA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt. #4		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Busse				4. DATE OF DEATH Month Day Year Sept. 11, 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1892	
9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Herman Busse		13b. MOTHER'S MAIDEN NAME Katherine Sattmoeller		14. NAME OF HUSBAND OR WIFE Florence Busse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 490 14 7960		17. INFORMANT Address Rt. 4 Florence Busse Sullivan, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROSIS DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1957 to SEP 11 60 and last saw him alive on SEP 11-1960 Death occurred at 10:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert E. Busse				22b. ADDRESS Sullivan Mo		22c. DATE SIGNED Sept 12 60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery		23d. LOCATION (City, town, or county) Lonedell, Mo.	
24. FUNERAL DIRECTOR Casey Lenox St. Clair, Mo.				25. DATE RECD. BY LOCAL REG. 9/14/60		26. REGISTRAR'S SIGNATURE J. P. Hickman	

(Licensed Embalmer's Statement on Reverse Side)

SEP 20 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. M. Lenox, Jr.
Licensed Embalmer No. 5090
P. O. Address St. Clair,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.